

REQUEST FOR RENEWAL OF CBS/MIS CRIMINAL HISTORY INFORMATION

FOR HEALTH FACILITY EMPLOYMENT PURPOSES

DEPARTMENT OF HEALTH - BUREAU OF LICENSING

PO BOX 142003 - 288 N. 1460 W. - Salt Lake City, UT 84114-2003

1. REQUESTING FACILITY

Facility Name

Mailing Address

City/State/Zip Code

Requestor's Name

Title

Area Code & Phone Number

I certify this request is made pursuant to UCA 26-21-9.5, for employment with health care facilities, and that all information provided on this form is true and accurate. I understand that further dissemination or other use of any criminal history information is prohibited by law. I further certify that Disclosure Statements have been signed by all applicants and are on file with this facility. I understand that signed statements must be furnished upon request for verification.

2. APPLICANT NAMES

Note: A ✓ mark in the box prior to the applicant name indicates a criminal conviction, pending charges, or substantiated findings have occurred in the last twelve (12) months and documentation will be attached.

PRINT OR TYPE

√*	Last Name	First	Middle	Date of Birth	Social Security #	Drivers License #

FOR DEPARTMENT USE ONLY -USE ADDITIONAL SHEETS AS NEEDED

DATE RECEIVED	MIS APPROVAL STAMP	CBS APPROVAL STAMP